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RESOURCE PAPER

SCHIP Innovations for Children with Special Needs in Managed Care

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235

Table of Contents

Executive Summary

Interest in children with special health care needs has increased markedly in recent years. This has been stimulated by a federal definition of children with special health care needs and research leading to the development of a screening instrument to make the definition operational and enable states to measure satisfaction and quality of care. At the same time, state experiences have shown that standard managed care arrangements do not always adequately serve this population, and families have brought to the foreground numerous managed care issues concerning quality and access. The Healthy People 2010 objectives to achieve comprehensive care within a medical home, adequate health insurance protection, early identification of chronic conditions, community-based service systems, and greater family involvement in their children's care have further focused attention on the varied and extensive service requirements of children with special needs.

This Resource Paper provides new information about the array of State Children's Health Insurance Program (SCHIP) policies and practices affecting children with special health care needs in the 39 states that contract with managed care organizations (MCOs) and highlights those that are most innovative. It examines state SCHIP policies concerning covered services, MCO enrollment and benefit responsibilities for children with special health care needs, state policies for defining and identifying this population, and specific contract provisions to assure the availability of specialty care.

Information for this Resource Paper was obtained from managed care contract documents in effect at the end of January 2002 and telephone interviews with SCHIP officials during the winter and spring of 2002. Key findings are summarized below.

SCHIP Covered Services

- More than half of the 39 states contracting with MCOs provide a full Medicaid benefit package, including five states with separate SCHIP programs. The remaining 18 states operating separate SCHIP programs cover, but restrict the amount, duration, and scope of most specialized health services required by children.
- MCO contracts in more than three-quarters of the 39 states include a medical necessity standard to guide plans' coverage determinations. The remaining quarter of states give plans full discretion to make coverage decisions.
- Four states with separate SCHIP programs — Alabama, California, Connecticut, and Montana — have adopted innovative approaches to augment the basic benefits for children with special health care needs meeting state-defined criteria.

MCO Enrollment Policies and Benefit Responsibilities

- Among the 39 states contracting with MCOs, almost two-thirds mandate such enrollment statewide. Seven states exempt certain groups of children with special health care needs, such as those with serious emotional disturbances or those receiving Title V services from mandatory MCO enrollment. More than three-quarters of states using MCOs carve out at least one service used by children, most often dental, mental health, health-related special education, and substance abuse treatment services.
- Three states — Florida, Michigan, and Wisconsin — have designed separate managed care plans specifically to serve children with special health care needs.

Definition and Identification of Children with Special Health Care Needs

- More than a third of states using MCOs include a definition of children with special health care needs in their managed care contracts. These definitions are usually broad, extending well beyond those with disabilities or functional limitations.
- Two-thirds of states using MCOs have a policy for identifying children with special health care needs either through the SCHIP agency or its enrollment broker or through the MCOs. In most states, these children are identified, usually for the purpose of case management, at the time of enrollment.
- Three states in particular — Iowa, Oklahoma, and Texas — have developed innovative approaches to identifying children with special health care needs and are using this information to achieve care improvements.

Contract Requirements for Specialized Care

- About 40 percent of states that enroll children into MCOs require MCOs to coordinate with public programs, most often providers of early intervention, special education, child welfare services, and children's mental health services. Slightly more states require MCOs to develop treatment plans for children with special needs. Slightly fewer specify that MCOs provide comprehensive case management to assist children in coordinating medical services as well as a range of community-based services.
- In more than half of the states, SCHIP programs stipulate that MCO networks include pediatric providers, but the type of required providers varies. Public program contracting requirements are specified less often.
- The most common access requirements are appointment standards. Other access requirements concern travel times, out-of-network options, direct access to specialists, and use of specialists as primary care providers.
- Three states — Nebraska, New Jersey, and Oklahoma — have particularly innovative case management and treatment plan requirements. Five states — Maryland, Missouri, New Jersey, Texas, and Utah — have a broad set of provider network or access requirements.

Introduction

Children with special health care needs represent a significant segment of the SCHIP population. These are children who, according to the federal Bureau of Maternal and Child Health and the American Academy of Pediatrics, have or are at risk for a chronic physical, developmental, behavioral, or emotional condition requiring health and related services of a type or amount beyond those required by children generally.[1] In addition, an estimated 15 percent of children enrolled in SCHIP can be considered to have a special health care need.[2] These children, unlike adults with special needs, typically have conditions with relatively low prevalence, although attention deficit hyperactivity disorder, asthma, and depression are notable exceptions. The types of services they may require include pediatric subspecialty care, prescription medications, ancillary therapies, mental health services, health risk assessments, comprehensive case management, and treatment plans. Not surprisingly, this vulnerable population presents unique challenges for SCHIP officials.

The purpose of this Resource Paper is to examine state SCHIP policies and practices affecting children with special health care needs and to highlight those that are most innovative, comprehensive, or effective. Given that 39 states rely on managed care organizations (MCOs) to serve SCHIP-eligible children, we elected to focus on these states and to examine, in particular, their plan enrollment policies and the requirements they place on MCOs for delivering specialized services, identifying the special-needs population, and implementing safeguards to assure these children's access to care.

Of the 39 states, we found, as of January 31, 2002, that 17 (or 44 percent) operate separate, non-Medicaid, SCHIP programs,[3] 11 (or 28 percent) operate Medicaid SCHIP programs, and 11 (or 28 percent) operate combination programs, providing Medicaid coverage only to the lower income segment of their eligible populations. General details of SCHIP programs are outlined below.

- Separate SCHIP programs are being used exclusively in Alabama, Arizona, California, Colorado, Delaware, Kansas, Mississippi, Montana, Nevada, New York, North Dakota, Oregon, Pennsylvania, Texas, Utah, Virginia, and Washington.
- Medicaid SCHIP programs are being used exclusively in the District of Columbia,[4] Hawaii, Minnesota, Missouri, Nebraska, New Mexico, Ohio, Oklahoma, Rhode Island, South Carolina, and Wisconsin.
- Combination separate and Medicaid programs are being used in Connecticut, Florida, Illinois, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Michigan, New Hampshire, and New Jersey.

Income eligibility across the 39 states enrolling SCHIP children into MCOs varies considerably, ranging from a low of 140 percent of the federal poverty level in North Dakota to a high of 350 percent of poverty in New Jersey, as shown in Appendix Table I. Nevertheless, children whose families have incomes at or above 200 percent of poverty are eligible for SCHIP coverage in three-quarters of these states. States operating separate programs, either alone or in combination with Medicaid, are more likely than states operating Medicaid programs exclusively to provide SCHIP coverage to children in higher income families.

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[1] McPherson M. et al. "A New Definition of Children with Special Health Care Needs." *Pediatrics*. 102: 1137-1140, 1998.

[2] Children identified as having a special need are those who have a medical, behavioral, or other health condition that is expected to last a year or longer and have one or more of the following consequences: functional limitation; need or use of prescription medications, specialized therapies, or treatment or counseling for an emotional, behavioral, or developmental problem; or health care service use and type above what might be expected. Shenkman B. *The Health Status and Health Care Use of SCHIP Enrollees*. Presentation before the Agency for Healthcare Research and Quality. Institute for Child Health Policy, August 2002.

[3] We counted as states with separate programs the five states (Alabama, California, Mississippi, North Dakota, and Texas) using a Medicaid-expansion SCHIP program only to accelerate the phase-in of adolescents with family incomes up to 100 percent of poverty into Medicaid since the phase-in was completed on October 1, 2002. At the same time, the age limit for children in families with poverty-level incomes decreased for SCHIP. For the same reason, Tennessee was excluded from the analysis.

[4] For the purposes of this Resource Paper, the District of Columbia is considered a state.

In each section of this Resource Paper, we analyze differences between states using separate programs and states using Medicaid programs. To categorize states with combination programs, we relied on enrollment data from the Centers for Medicare and Medicaid Services.[5] If the majority of a state's SCHIP-eligible children were enrolled in the Medicaid program, we categorized it as a Medicaid state.[6] If the majority were enrolled in the separate program, we categorized it as a separate program.[7]

Information for this Resource Paper was based on a review of SCHIP managed care contracts in effect as of January 2002 and on telephone interviews with SCHIP officials during the winter and spring of 2002. The response rate was 100 percent.

SCHIP Covered Services

SCHIP benefit packages among the 39 states using MCOs vary considerably with respect to coverage for services required by children with special health care needs, but most are very generous (Appendix Table II). At one extreme are the 21 states that provide a full Medicaid benefit package covering all medically necessary services — of which 16 enroll SCHIP-eligible children into their state Medicaid programs, four enroll them into separate programs that cover additional diagnostic and treatment services equivalent to Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit,[8] and one enrolls them into a separate program that provides unlimited coverage for all of the services allowed under Medicaid law rather than covering additional benefits through EPSDT.[9] At the other extreme is the one state that provides no coverage for case management services, ancillary therapies, nursing care services, home health care, disposable medical supplies, over-the-counter drugs, or medical transportation, and minimal coverage for mental health services and dental care. In general, however, separate SCHIP programs offer basic medical services, such as physician services, prescription drugs, laboratory and radiology services without limits, and provide varying degrees of coverage for ancillary therapies, home health care, mental health and substance abuse treatment services, and other specialized services.

With the exception of the five states offering Medicaid-equivalent coverage, states operating separate SCHIP programs impose amount, duration, or scope restrictions on most services important to children with special needs, as shown in Table 1. For children with complex physical or developmental conditions, the extent of coverage for specialized services varies significantly in these 18 states. Physical, occupational, and speech therapies are typically covered for at least 24 visits for all therapies combined, but often are available only for acute episodes resulting from illnesses or injuries and not for children with developmental delays or conditions that will not improve significantly. Only one state lacks coverage for any of the ancillary therapy services. Although home health services are usually covered without visit or dollar limits, they are sometimes restricted to skilled nursing and are provided only in lieu of hospitalization or skilled nursing facility care and rarely include respite or personal care services. Only in one state is home health coverage not provided. All the states cover durable medical equipment.[10] Coverage for hearing aids or eyeglasses is excluded in several states, and dollar limits apply in a few states. All but one state covers disposable medical supplies, although coverage is sometimes limited to diabetic supplies. Other services required by children with special health care needs, such as private duty nursing, non-emergent medical transportation, and over-the-counter medications, are covered less frequently.

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5 *The State Children's Health Insurance Program Quarterly Enrollment Report, Second Quarter Fiscal Year 2002: January 1, 2002-March 31, 2002.* Centers for Medicare and Medicaid Services, July 2002. www.cms.gov/schip.

6 The following combination programs are categorized as Medicaid programs: Illinois, Indiana, Kentucky, Maryland, and Massachusetts.

7 The following combination programs are categorized as separate programs: Connecticut, Florida, Iowa, Michigan, New Hampshire, and New Jersey.

8 These four states are Arizona, Kansas, Nevada, and Washington.

9 This state is Oregon.

10 However, in New Jersey, coverage for durable medical equipment is provided only for children in families with incomes up to 200 percent of poverty, not for children in families with incomes between 200 percent and 350 percent of poverty.

Table 1: Separate SCHIP Program Coverage of Specialized Services,* 2002

Services	States Providing Coverage	
	With Limits	Without Limits
Physical Therapy	13 (72%)	4 (22%)
Occupational Therapy	14 (78%)	3 (17%)
Speech Therapy	15 (83%)	2 (11%)
Home Health		
Skilled nursing	9 (50%)	8 (44%)
Home health aide	7 (39%)	6 (33%)
Personal care	0 (0%)	0 (0%)
Durable Medical Equipment	9 (50%)	9 (50%)
Disposable Medical Supplies	5 (28%)	12 (67%)
Nursing Care		
Private duty nursing	3 (17%)	8 (44%)
Inpatient mental health		
Inpatient hospital	15 (83%)	3 (17%)
Residential treatment	6 (33%)	3 (17%)
Outpatient Mental Health		
Outpatient treatment	15 (83%)	3 (17%)
Partial hospitalization	8 (44%)	2 (11%)
Inpatient Substance Abuse		
Detoxification	13 (72%)	4 (28%)
Inpatient hospital	10 (56%)	2 (11%)
Residential treatment	6 (33%)	2 (11%)
Outpatient Substance Abuse		
Outpatient treatment	16 (89%)	2 (11%)
Partial hospitalization	0 (0%)	2 (11%)

*These are the benefits covered in the 18 states with separate SCHIP programs that do not offer Medicaid-equivalent coverage.

Children with behavioral health conditions also would have highly variable access to needed services in the 18 states without Medicaid-equivalent coverage. All of these states cover inpatient mental health services for at least 15 days, but coverage is sometimes restricted to services provided in a general acute care hospital, and day limits are common. While all the states cover inpatient detoxification services, only 12 cover lengthier inpatient hospital stays for substance abuse treatment services, and day and dollar limits are common. Residential treatment services for mental health conditions are available in more than half of the states, although often not as a distinct benefit but only in lieu of hospitalization. Outpatient mental health services are available in all the states, but visit limits — ranging from 20 to 60 visits per year — are common. More than half of the states also cover partial hospitalization services, but usually only as a conversion option. Applicable limits are lifted in three states for children with selected biologically based disorders.[11] Yet, in two states, outpatient mental health treatment is not covered at all for children with certain conditions, such as learning disabilities, mental retardation, conduct disorders, and oppositional disorders.[12] Outpatient substance abuse treatment services are available in all the states,[13] but partial hospitalization services are rarely covered. Moreover, coverage for mental health and substance abuse treatment services is frequently combined and subject to a single benefit limit, which may adversely impact access by those with co-existing conditions.

Several states with separate SCHIP programs have adopted innovative approaches to augment the basic benefits available for children with special health care needs who meet state-defined criteria. Of these four states, three have chosen to provide additional benefits for specialized health care services to children with chronic physical or developmental conditions and to provide additional behavioral health benefits to children with serious mental health or substance abuse problems. The other state provides supplemental mental health benefits to children diagnosed as seriously emotionally disturbed.

- Children in Alabama who meet the Maternal and Child Health Bureau's broad definition of children with special health care needs and who require a service provided by at least one of four participating state agencies[14] are eligible for supplemental services through the AllKids Plus program. Each agency offers an array of services that may include durable medical equipment, audiology services, respite care, personal care, homemaker services, nutrition services, ancillary therapies, mental health and substance abuse treatment services, and case management. Children are identified on the basis of health screenings administered at the time of enrollment and referrals by primary care providers. Each agency determines the services required.
- California augments the regular benefit package with additional specialty services available for children with severe physical and developmental conditions and those with serious emotional disturbances.[15] Children eligible for the Title V program, California Children's Services (CCS), receive all diagnostic, outpatient treatment, hospital, rehabilitation, and follow-up care related to their condition, as well as case management. CCS provides services through its network of approved pediatric providers and specialty care centers to children with selected chronic physical and developmental conditions that require tertiary level, multidisciplinary, or multi-specialty care. Children with serious emotional disturbances[16] receive all case management, outpatient therapy, day treatment, residential treatment, and psychiatric hospital services-except for 30 days of inpatient care that remains the MCO responsibility-from the state's county mental health system. Both programs make their own eligibility determinations based on referrals from MCOs.

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[11] These states are Colorado, Montana, and New Hampshire.

[12] These states are Iowa and Utah.

[13] However, New Jersey covers outpatient substance abuse services only for children in families with incomes up to 200 percent of poverty, not for children in families with incomes between 200 percent and 350 percent of poverty.

[14] These agencies are: 1) Department of Mental Health and Mental Retardation, 2) Department of Rehabilitation Services, Division of Children's Rehabilitation Services (Title V), 3) Division of Early Intervention, and 4) University of Alabama, Sparks Clinics. The Sparks Clinics provide multidisciplinary, developmental assessments for children with suspected learning and developmental delays.

[15] For an in-depth analysis of the implementation of the wraparound benefits in California, see Fox H, McManus M, and Limb S. *Access to Care for SCHIP Children with Special Health Care Needs*. Kaiser Commission on Medicaid and the Uninsured, December 2000; and Fox H, McManus M, and Limb S. *SCHIP Implementation in California*. Kaiser Family Foundation, April 2001.

[16] In California, children who have a serious emotional disturbance are those who have a mental disorder other than a primary substance abuse disorder or developmental disorder and who meet one or more of the following criteria: 1) has impairments in at least two functional areas (self care, school functioning, family relationships, or ability to function in the community) and either has been removed or is at risk for removal from home or has a condition and impairments that have persisted for six months and are expected to continue a year or longer without treatment, 2) shows psychotic features or risk of suicide or violence due to a mental disorder, or 3) meets the special education eligibility requirements.

- In Connecticut, children with physical or developmental problems or serious mental or substance abuse disorders are eligible for services additional to those offered as standard SCHIP benefits.[17] Those who have or are at risk for any of a broad range of physical or developmental conditions that are covered by the Title V program and associated with elevated service needs qualify for the HUSKY Plus Plan for Children with Special Physical Health Needs. The Plus Physical Plan pays for services not otherwise covered, including case management, family advocacy, multidisciplinary team conferences, hearing aids, orthodontia, and specialized medical equipment, and also offers expanded coverage for services subject to benefit limits, such as ancillary therapies and home health care. Children who have a severe mental health or substance abuse problem are able to receive additional behavioral health services from the HUSKY Plus Behavioral program. The Plus Behavioral Plan covers services omitted from the basic SCHIP benefit package, such as intensive in-home services, mobile crisis services, and case management, and also provides coverage for additional outpatient and inpatient services when the basic benefit has been exhausted.[18] The Yale University School of Medicine and the Center for Children with Special Health Care Needs at Connecticut Children's Medical Center jointly administer the Plus Physical Plan, and the Yale Child Study Center administers the Plus Behavioral Plan. Both make their own eligibility determinations based on referrals made by MCOs, providers, and families.
- In Montana, children with serious emotional disturbances may receive unlimited mental health services from the state's public mental health program once they exhaust the benefits in the basic SCHIP plan. The supplemental benefits include outpatient services, inpatient services, residential treatment services, case management services, and crisis intervention services. A national behavioral health company, under contract to the state, makes eligibility determinations based on the clinical history obtained from the child's provider.

In all states using MCOs, those operating Medicaid programs as well as those operating separate programs, decisions regarding authorization of coverage for specialty services are often made on a case-by-case basis by the MCOs according to medical necessity criteria. Thirty contracts include a medical necessity standard for plans to abide by when making coverage determinations. The remaining nine states give MCOs full discretion to make these determinations according to their own management policies, as shown in Table 2. Among states with separate programs, more than a third provide no medical necessity standard, compared with six percent of states with Medicaid programs.

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[17] For an in-depth analysis of the implementation of the HUSKY Plus Programs in Connecticut, see Fox H, McManus M, and Limb S. *Access to Care for SCHIP Children with Special Health Care Needs*. Kaiser Commission on Medicaid and the Uninsured, December 2000.

[18] In Connecticut, HUSKY Plus Behavioral does not cover acute inpatient hospital care, residential psychiatric treatment, or residential substance abuse rehabilitation.

Table 2: SCHIP Contract Language Concerning Medical Necessity Criteria, 2002

Medical Necessity Criteria	States
States with Medical Necessity Definition in Contract	30 (77%)
Criteria for Scope of Health Problems Included	28 (93%)
Services for preventive purposes as well as diagnostic and treatment purposes	18 (60%)
Treatments for conditions or disabilities as well as illnesses and injuries	25 (83%)
Treatment only for illnesses and injuries	2 (7%)
Evidence of Effectiveness Required*	24 (80%)
Conformance with standards of accepted medical practice	13 (43%)
Conformance with guidelines of medical, research, government, or health care organizations	1 (3%)
Demonstrated evidence of effectiveness or proven medical value	6 (20%)
Evidence of effectiveness based on well-controlled, peer-reviewed studies	3 (10%)
Conformance with standards of the managed care industry	1 (3%)
Cost Considerations Required	16 (53%)
Most appropriate level of services that can safely be provided	6 (20%)
Most cost-effective or least costly treatment with equal effectiveness	4 (13%)
Most cost-effective or least costly setting	3 (10%)
Most cost-effective or least costly alternative treatment	3 (10%)

*These criteria are mutually exclusive and meant to capture the most stringent criterion in a contract. If a contract requires that more than one criterion be met in this category, this in not reflected in the table.

The medical necessity language used by the 30 states establishes the scope of qualifying interventions in all but two instances. Eighteen states stipulate that medically necessary services include services for preventive purposes as well as diagnosis and treatment.[19] Even more states (25) stipulate that they include treatment for conditions and disabilities as well as illnesses and injuries. Interestingly, states with Medicaid SCHIP programs have standards that are more likely to encompass services for preventive purposes (73 percent vs. 47 percent) but are less likely to encompass treatments for conditions or disabilities (67 percent vs. 100 percent). Only two states characterize medically necessary services as being for the treatment of illnesses and injuries alone.

With respect to evidence of effectiveness, there are 24 states that include some type of criterion, with the majority using as their most stringent criterion the customary requirement that services conform to accepted medical practice. Much less common are requirements pertaining to national guidelines and demonstrated evidence of effectiveness. Nonetheless, four states do apply the most rigorous criteria, directing MCOs to consider services as medically necessary only if they show evidence of effectiveness based on well-controlled, peer-reviewed studies or if they conform to standards of the managed care industry. States with separate programs were more likely to have effectiveness requirements than those with Medicaid programs (87 percent vs. 73 percent), but were no more likely to use the most stringent effectiveness requirements (13 percent and 13 percent).

A smaller proportion of states, yet still over half (16) of those with medical necessity standards, require cost criteria. Six require only that MCOs provide the most appropriate level of services that can safely be provided, but most require some consideration of cost effectiveness. Seven states limit medically necessary services to the most cost-effective or least costly treatment among alternatives with equal effectiveness or else require cost effectiveness only with respect to service settings. Only three states, however, impose the most stringent criterion that medically necessary services be the most cost-effective or least costly alternative treatment available. States with separate programs are more likely to stipulate some type of cost requirement than states with Medicaid programs (67 percent vs. 47 percent), but are less likely to use the most stringent criterion regarding cost (7 percent vs. 13 percent).

As many as 13 states have medical necessity standards that encompass services for preventive purposes and treatments for conditions or disabilities and do not require either that services show evidence of effectiveness based on peer-reviewed studies or MCO standards or that they be the least costly alternative.[20] These states vary in the specificity of their standards. In two states, for example, medical necessity definitions focus broadly on the prevention and treatment of health problems, and include the goal of maximum functional capacity and include a comprehensive listing of service categories.

- Kentucky's Medicaid SCHIP contract establishes that medically necessary services are age-appropriate and are reasonable and necessary to diagnose and provide preventive, palliative, curative, or restorative treatment for physical or mental conditions in accordance with professionally recognized standards of health care generally accepted at the time services are provided, and in accordance with 42 CFR 440.230,[21] including services for children authorized under 42 USC 1396d(r).[22]

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19 For a thorough discussion of the methodology used to analyze states' medical necessity standards, see Fox H, McManus M, and Hayden M. *An Analysis of Medical Necessity Standards in States' Medicaid Managed Care Contracts*, 1995-1999. MCH Policy Research Center, January 2000.

20 The states are Connecticut, Delaware, District of Columbia, Kentucky, Minnesota, New Hampshire, New Mexico, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Washington, and Wisconsin.

21 This section of the Code of Federal Regulations states that services may not be arbitrarily denied or reduced because of an enrollee's diagnosis, type of illness, or condition.

22 This section of the U.S. Code specifies the requirements for the EPSDT program.

- The standard used by Oklahoma's Medicaid SCHIP program defines medically necessary services as medical, dental, behavioral, rehabilitative, or other health care services that are reasonable and necessary to prevent illnesses or medical conditions or to provide early screening, interventions, or treatment for conditions that cause suffering, pain, physical deformity, limitation in function, illness, infirmity or that endanger life or worsen a disability; are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical condition; are consistent with the diagnosis of the condition; are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence; and will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account the individual's capacity and those that are appropriate for individuals of the same age.
- Pennsylvania's separate program contract stipulates that a medically necessary service will, or is reasonably expected to, prevent the onset of an illness, condition, or disability; will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account the functional capacity of the member and those that are appropriate for members of the same age.

MCO Enrollment Policies and Benefit Responsibilities

With only a few exceptions, the 39 states using MCOs to serve the SCHIP population at the beginning of 2002 relied on private insurers that employ a high degree of managed care controls, such as primary care provider approval for specialty services, and put these insurers at full risk for providing contracted services. Only four states[23] used traditional insurance plans with fewer cost and utilization controls for SCHIP children. The four states, all of which operate separate SCHIP programs and have large rural populations and minimal managed care penetration, contracted with BlueCross BlueShield plans statewide. In addition, two states[24] used partial-risk bearing preferred provider organizations, but only in selected rural areas.

Most of the 39 states (34) make MCO enrollment mandatory (Appendix Table III on page 34). Ten states require MCO enrollment only in some counties and use other arrangements in the rest of the state – primary care case management systems (PCCMs), fee-for-service, or preferred provider organizations – while 24 require all SCHIP-eligible children to enroll in MCOs. Only five states, all with Medicaid programs, have a voluntary MCO enrollment policy: three offer a choice between enrolling in an MCO or a PCCM, and two provide the option to remain in the fee-for-service system. States operating separate programs are much more likely to mandate MCO enrollment on a statewide basis than states operating Medicaid programs (74 percent vs. 44 percent).

Some states contracting with MCOs exempt certain groups of children with special needs or individuals with special health requirements from enrollment, although several allow them to enroll voluntarily. Exemption policies are in effect for children served by the Title V program in three states,[25] children participating in the early intervention program in one state,[26] children receiving developmental disability services in two states,[27] children determined to need mental health services because of a serious emotional disturbance in

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23 These states are Alabama, Mississippi, Montana, and North Dakota.

24 These states are Colorado and Utah. In Colorado, the state contracts directly with providers in rural counties, and a third party administers the network for a monthly capitation payment. In Utah, the state contracts with a preferred provider organization administered by the state employees' health plan which receives a monthly capitation payment. In both states, the plans are paid the difference between the capitation rates and actual expenditures.

25 These states are Florida, Michigan, and Missouri. In Florida, children eligible for Title V services and those who qualify as having a serious emotional disturbance must enroll in a specialty plan. In Michigan, children eligible for Title V services may enroll in a specialty plan. In Missouri, Title V children are exempt from mandatory enrollment and may remain in the fee-for-service system but may enroll voluntarily in an MCO.

26 This state is Wisconsin, which exempts children in the state's early intervention program from mandatory enrollment and allows them to enroll.

27 These states are Arizona, which requires developmentally disabled enrollees to enroll in a specialty plan, and Minnesota, which excludes these children from all MCO enrollment.

two states,[28] and children with selected physical health conditions in one state.[29] More states (seven) have policies allowing for exemptions on an individual basis with evidence of a disability or severe medical problem that cannot be adequately served by participating MCOs. Only two states exempt more than one group of children and also individuals.[30]

In structuring their contractual arrangements with MCOs, states are more likely to carve out specialty services than groups of children with special needs. Most states (30) carve out at least one covered service used by children, especially those with special needs, and some as many as eight services. Half pay for dental services separately, and almost as many have separate payment arrangements for mental health services, health-related special education services, and substance abuse treatment services, as shown in Table 3. Ten states have a separate payment arrangement, usually with a commercial behavioral health plan, for all mental health and substance abuse services. The other states pay separately, usually on a fee-for-service basis, for only some mental health or substance abuse treatment services — either intensive services beyond specified plan limits or community-based services, such as residential treatment for children with serious behavioral conditions.

Table 3: SCHIP Program Service Carve-Out Policies, 2002

Excluded Services	States
States Carving Out at Least One SCHIP Service	30 (77%)
Dental	19 (63%)
Prescription Drugs	2 (7%)
Personal Care	5 (17%)
Durable Medical Equipment	0 (0%)
Ancillary Therapies	3 (10%)
Vision Services	2 (7%)
Private Duty Nursing	1 (3%)
Home Health	0 (0%)
Mental Health Services	18 (60%)
All or most	12 (40%)
Intensive services	1 (3%)
Community-based services for serious emotional disturbances	5 (17%)
Substance Abuse Services	15 (50%)
All or most	11 (37%)
Intensive services	0 (0%)
Community-based services for severe chemical dependency problems	4 (13%)
Targeted Case Management	10 (33%)
Title V/Children with Special Needs	0 (0%)
Health-Related Special Education	18 (60%)
Early Intervention Services	10 (33%)

[28] These states are Minnesota and Wisconsin, which exempt children with serious emotional disturbances from mandatory enrollment.

[29] This state is Maryland, which exempts children with any of a select list of complex physical diagnoses from mandatory enrollment and allows them to enroll in the fee-for-service Rare and Expensive Case Management Program.

[30] These states are Minnesota and Wisconsin.

There are significant differences in carve-out policies between states with Medicaid SCHIP programs and those with separate programs. Not surprisingly, states with Medicaid programs carve out more services than states with separate programs — an average of 4.3 services versus 1.5 services. They also are more likely to carve out specialized services that are provided by other public programs and are intended for children with special needs. These services are usually not covered benefits in separate programs. States that carve out these services do so to protect certain populations of children and to assure the continuity of their care or to preserve financing for service providers that rely heavily on public funds. Among Medicaid SCHIP programs, carve-out policies are in effect for health-related special education in 13 states, for early intervention services in ten states, and for targeted case management services in nine states. Still, five states with separate programs have elected to cover and pay separately for health-related special education services, and one has chosen to do this for targeted case management for children with mental health problems.

Importantly, three states have designed separate managed care plans specifically to serve children who have special needs. These include two states with separate SCHIP programs (Florida and Michigan) and one state with a Medicaid program (Wisconsin). Florida's specialty plan includes essentially all children with complex physical and developmental conditions and a small subset of those with mental health conditions, while Michigan's and Wisconsin's include a select group — those with chronic physical conditions and those with serious emotional disturbances, respectively.

- Children with a chronic physical or developmental condition[31] and a limited number of children with serious emotional disturbances[32] in Florida must enroll in the state's specialty MCO, the Children's Medical Services Network (CMS), which is administered by the state Title V program. Eligible children receive full Medicaid benefits. Children who indicate at the time of SCHIP enrollment that they have a chronic physical or developmental condition are referred to the Title V program to determine their medical eligibility for CMS, while those classified as seriously emotionally disturbed by local school districts are referred to the Title V program where their eligibility is verified and prioritized because of a waiting list.[33] Services are provided by participating private providers, hospitals, multidisciplinary specialty clinics, and the state's publicly funded children's mental health system. Enrollees select a primary care provider, and providers are paid on a fee-for-service basis. CMS receives separate capitation payments for children with physical or developmental conditions and for children with serious emotional disturbances.
- Children in Michigan with complex chronic physical conditions[34] who want to receive both SCHIP and Title V benefits may enroll in the state's specialty managed care plan, Children's Special Health Care Services (CSHCS), which is administered by the state's Title V program. CSHCS contracts with two MCOs, which together serve about half of the state's counties.[35] There is no formal process of identifying potentially eligible children, but children are referred by their providers, pediatric regional centers, and SCHIP MCOs. The specialty MCOs' networks include pediatric subspecialists, ancillary therapists, home health providers, and hospitals with expertise and training in caring for children with special needs as well pediatric regional centers and multidisciplinary specialty clinics. A pediatric subspecialist serves as the primary care provider and develops a treatment plan and coordinates the child's care. The MCOs

[31] To meet the medical eligibility criteria for CMS, a child must have a serious, chronic physical or developmental condition that requires extensive preventive and maintenance care beyond that required by typically healthy children.

[32] To meet the severe emotional disturbance eligibility criteria for CMS, a child must have a diagnosis of schizophrenia or other psychotic disorder, major depression, mood disorder, or personality disorder; diagnosis of another allowable *Diagnostic and Statistical Manual of Mental Disorders* diagnosis and a Children's Global Assessment Scale score of 50 or below; or currently classified as a student with serious emotional disturbance by a local school district. Ineligible conditions are mental retardation, pervasive developmental disorder, substance abuse, communication disorders, learning disorder, and V-codes.

[33] The state has between 330 and 350 openings available in the CMS program for SCHIP-eligible children with a serious emotional disturbance.

[34] Children with one of about 2,700 physical diagnoses may be eligible for the specialty program depending on the severity and long-term effects of the condition. Autism, dyslexia, emotional disorders, learning disabilities, and mental retardation are ineligible diagnoses.

[35] Eligible children in the counties where the specialty MCOs do not operate who wish to receive both SCHIP and Title V services must enroll in the SCHIP BlueCross BlueShield Plan, which provides the SCHIP benefits while the Title V program provides the specialty services related to the child's condition. Children eligible for Title V services but who choose not to receive them enroll in a basic SCHIP plan and receive only SCHIP benefits, not specialty benefits.

receive two capitation payments: one for basic SCHIP benefits, adjusted for age and geographical location, and another for the specialty services, adjusted for the child's eligible diagnosis.[36] The MCOs, however, do not yet accept full risk; the Title V program currently pays the difference between service expenditures and capitation payments.

- Two counties in Wisconsin operate specialty capitation arrangements for children with severe emotional disturbances[37] who are at imminent risk of institutionalization. The state Medicaid agency has entered into contracts with the Dane County Department of Human Services to administer Children Come First (CCF) and the Milwaukee County Mental Health Department to administer Wraparound Milwaukee. In both counties, the agencies provide mental health services, alcohol and drug abuse treatment, and targeted case management services, using providers paid on a fee-for-service basis. Case managers develop treatment plans and authorize services. Children receive all other services from Medicaid providers paid fee-for-service.

Definition and Identification of Children With Special Health Care Needs

At the beginning of 2002, 15 of the 39 states enrolling children into MCOs included in their contracts a definition of children with special needs. States operating separate SCHIP programs were far more likely to provide definitions than states operating Medicaid programs (44 percent vs. 31 percent). In most cases, the definitions they use are very broad, as shown in Table 4. Six states adopted verbatim, or with some modification, the definition recommended by the federal Maternal and Child Health Bureau,[38] which includes "children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[39] Another four that crafted their own language exclude the at-risk population but capture almost all children with diagnosed chronic physical, developmental, behavioral, and emotional conditions.[40] Of the remaining five states that define the population more narrowly, four have definitions that pertain only to children with serious and disabling chronic conditions, and three of these focus only on children with physical or developmental problems. The final state, which uses the definition specified in the Balanced Budget Act of 1997 (BBA) and the applicable regulations, in effect also captures only children with primarily physical conditions that are serious or disabling, since children in the BBA categories other than those covered by the state's Title V program would not be eligible for SCHIP.[41,42]

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[36] There are 56 diagnosis-based rate cells.

[37] To qualify as seriously emotionally disturbed, children must: 1) have a diagnosable mental or emotional disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV); 2) have a mental or emotional disorder that has persisted for six months and is expected to persist for a year or longer; 3) be receiving services from two or more of the following service systems -- mental health, social services, child protective services, juvenile justice, or special educations; and 4) have either psychotic or dangerous symptoms or functional impairment in two of the following capacities – functioning in self care, functioning in the community, functioning in social relationships functioning in the family, and functioning at school/work.

[38] The three states using the MCHB definition verbatim are Connecticut, New Jersey, and New Mexico. Utah incorporated a functional limitation requirement, and Nevada and Wisconsin included the requirement that children be receiving Title V-funded services.

[39] McPherson M, Arango P, Fox H, McManus M, Newacheck P, Perrin J, Shonkoff J, Strickland B. "A New Definition of Children with Special Health Care Needs." *Pediatrics*. 102: 137-140, 1998.

[40] These states are Alabama, Colorado, Maryland, and Delaware.

[41] The state using the BBA definition is Arizona.

[42] The Balanced Budget Act of 1997 defines children with special health care needs as children under age 19 who are: receiving or related to the population receiving Supplemental Security Income (SSI) cash assistance because of a disability; are eligible for Medicaid under the Katie Beckett State Plan option [1902(e)(3)] because they have disabilities that would qualify them for SSI cash payments if they were in an institution; are in foster care or other out-of-home placement; are receiving foster care or adoption assistance; or are described in community-based, coordinated care programs under Title V. Public Law 105-33. The final implanting regulations define these Title V children to be receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs. Final Rule: Medicaid Managed Care; 42 CFR Part 400, et al. June 14, 2002.

Table 4: SCHIP Program Policies for Definition and Identification of Children with Special Health Care Needs, 2002

Definition and Identification Policies	States
States with Definition of Children with Special Needs	15 (38%)
MCHB definition	6 (40%)
BBA categorical definition	1 (7%)
Other definition	8 (53%)
Includes children with almost all physical, developmental, or behavioral conditions	4 (27%)
Includes only children with serious or disabling chronic physical, developmental, or behavioral conditions	1 (7%)
Includes only children with serious or disabling physical or developmental conditions	3 (20%)
States with Identification of Children with Special Needs	26 (67%)
MCO responsibility	11 (42%)
Specific health assessment tool	3 (12%)
SCHIP agency/enrollment broker responsibility	15 (58%)
Specific health assessment tool	8 (31%)
General question about special needs	5 (19%)
Report from Title V agency	5 (19%)

Among the 15 states that include definitions of children with special needs in their contracts, all but one have a policy for identifying these children, as shown in Table 4. States with separate programs are more likely to have an identification policy than states with Medicaid programs (39 percent vs. 31 percent). Only six states leave responsibility for identifying children with special needs exclusively to the MCOs, and they generally do not specify how it is to be done. MCOs reportedly use a variety of methods to comply with the requirement, including new member outreach calls, claims data analysis, and self-referrals to case managers. Only in two of these states are the MCOs given a specific health screening tool.[43]

In the other eight states, responsibility for identification rests with the state SCHIP agency and its enrollment brokers (although a few require MCOs to identify these children as well), and the use of health screening tools is far more common. All of the states require their enrollment brokers to identify children with special needs, of which five provide a formal screening tool to be administered at the time of enrollment. In three states, members are asked a single question about the presence of a special need on the SCHIP application form. Three states also obtain state Title V eligibility reports. Information regarding children flagged on the basis of screening or Title V eligibility is then forwarded to the MCOs where the children undergo a more comprehensive assessment by a case manager or clinical provider.

Interestingly, 12 of the 24 states that do not include a definition of children with special needs in their contracts also have a policy in effect for identifying children, or all enrollees, with a disability, chronic condition, or special health need. Such identification policies are found in greater proportions among states with Medicaid programs compared to those with separate programs (38 percent vs. 26 percent). Five states give the identification responsibility exclusively to the MCOs, and although one of these states requires the MCOs to use a particular screening tool, it is intended to identify only children with serious emotional disturbances. In the other seven states, the SCHIP agency or the enrollment broker is responsible for identifying these children. Of these, three use a health assessment tool at the time of enrollment, two include a single question about the presence of a special need on the SCHIP application form, and two rely on information provided by the Title V agency.

[43] These two states are Oklahoma and Texas. In Oklahoma, the state provides the MCOs with an assessment tool for identifying enrollees with special behavioral health needs for whom extra benefits are required. In Texas, the state requires MCOs to use the Foundation for Accountability's CSHCN Screener to identify children with complex, chronic conditions.

The identification of children with special needs, whether in states with or without a specific definition, is most often for the purposes of determining which children qualify for specialized case management services or the development of a treatment plan. As many as six states, however, identify these children so that they may be referred to a special managed care plan, as in Florida, or made eligible for additional benefits, as in Connecticut. The remaining states report various purposes for identifying children with special needs, including, in one state, enhanced payment for the MCOs, quality assurance, and assignment to a primary care provider.

In states that required the use of comprehensive health screening tools (more than one or two general questions) to identify a broad group of children with special health care needs, most developed their own tools and did so not only to identify children but also to characterize their service needs. This is especially true in the states that use the tools for comprehensive case management or to identify enrollees who require immediate services. Only two of the nine states requiring screening tools adopted the CSHCN screener,[44] and only one of these states is using the tool as it is intended; the other requires enrollees to positively answer all the questions to be identified as a child with special health care needs. Most of the state-developed screeners ask about selected, primarily physical, diagnoses, but provide enrollees with the opportunity to write in a condition not listed or otherwise indicate that they have a special need. Most also ask about current use of services and treatments such as medications, mental health, and durable medical equipment as well as historic use of services, such as hospitalizations, emergency room visits, dental and vision checkups, and well child care. Several states also ask about current providers and needs for social supports related to living arrangements, transportation, and interpreter or other language assistance.

Many state SCHIP officials commented on the challenges associated with identifying children with special health care needs. Among those with identification policies, a common problem, mostly for MCOs, was contacting new enrollees and administering questionnaires. Several states also noted the difficulty of determining the best identification method to use, particularly at the time of enrollment when they need to balance a customer-friendly application process with obtaining detailed health information. Some also raised concerns that the method used was yielding either too few or too many children with special needs. However, in several states with insufficient numbers identified, broad discretion was given to the MCO to identify children with special health care needs, and in another state where over-identification was the problem, a single question on the enrollment application asking about the presence of a chronic condition was the only means of identification.[45] Aside from the challenges of finding the right children, a few states expressed concern about the futility of the effort, given that MCOs lack sufficient financial resources to provide all necessary services once children are identified or that appropriate specialty providers are not always available to serve them. Among states without identification policies, officials frequently commented that only a small number of children with special needs were covered by SCHIP. They equated special needs with certain criteria for Medicaid-receiving SSI payments, being in foster care, or otherwise requiring institutionalization — and considered that the only SCHIP children with special needs were those receiving Title V services. A few states also reported that placing identification requirements on MCOs was inappropriate for commercial health insurance plans.

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[44] The CSHCN screener asks about the: 1) need for medications, 2) health care service use and type above what might be expected, 3) functional limitations, 4) need for special therapies, and 5) need for behavioral services. Bethell CD, Read D, Stein RE, Blumberg SJ, Wells N, and Newacheck PW. "Identifying Children With Special Health Care Needs: Development and Evaluation of a Short Screening Instrument." *Ambulatory Pediatrics*, Jan-Feb 2002; 2(1).

[45] This state, however, reportedly is developing four to five additional questions to include on the application to improve the identification process. enrollees who can be deemed eligible for enhanced payment is 2,000.

We found three states that implemented innovative identification policies. Two have adopted comprehensive screening methods to identify children with special health care needs to link them with services and to evaluate the SCHIP program. The third compensates MCOs for providing comprehensive case management and mental health services to identified children. Officials in each of the states believe their identification approaches are successful and have achieved care improvements.

- Iowa's separate program, although it does not have a definition of children with special needs, requires that a lengthy health screening tool be administered twice — once at the time of enrollment and again after a year of enrollment. The tool is used to evaluate the impact of the SCHIP program on access to care and health status of enrollees[46] and includes multiple questions about service use, unmet needs, functional status, and the presence of particular conditions. The most recent evaluation found that the SCHIP program had improved access to specialty care and children's health status.
- Oklahoma's Medicaid SCHIP program gives its MCOs financial incentives for providing services to two different groups of children identified as having narrowly defined special needs. MCOs receive enhanced payment for providing specialized case management to children with certain, primarily physical, diagnoses[47] as well as others whom the MCOs have petitioned to include.[48] They also receive enhanced payment, in the form of a separate monthly capitation payment[49] for providing additional mental health benefits[50] to children with intensive behavioral health needs.
- MCOs in Texas' separate program are required to use the CSHCN Screener[51] to identify children meeting its definition of children with special health care needs — those with complex, chronic physical, mental, and developmental conditions.[52] The state is clear in its expectations for children identified, requiring that MCOs provide comprehensive case management and allow them to have a specialist as a primary care provider and access to out-of-network care, if necessary.

Contract Requirements for Specialized Care

Coordination, Treatment Plans, and Case Management

A substantial number of states have contract provisions regarding program coordination, treatment plans, and comprehensive case management, all of which are important to children with special needs. Coordination with various public program services frequently required by children with special needs is stipulated in 16 states' MCO contracts, as shown in Table 5. Medicaid SCHIP programs are much more likely to have such contract language than states with separate programs (63 percent vs. 26 percent). The services most commonly referenced are early intervention, special education, child welfare, and children's mental health. A few states require MCOs to develop formal memoranda of understanding (MOUs) with other agencies governing referral relationships and care coordination.

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46 The University of Iowa's Public Policy Center evaluates the data and has published two reports on the SCHIP program's influence on access to care. Damiano P, Willard J, and Momany E. *Hawk-I Impact on Access and Health Status*. University of Iowa Public Policy Center, March 2001. Damiano P, Willard J, Momany E, and Tyler C. *Hawk-I Impact on Access and Health Status*. University of Iowa Public Policy Center, January 2002.

47 These conditions are cerebral palsy, cystic fibrosis, HIV/AIDS, hemophilia, sickle cell, schizophrenic disorders, quadriplegia, asthma, and autism. Also eligible for case management services are ventilator-dependent children, children receiving skilled nursing at home, and identified transplant candidates.

48 MCOs are paid $150 on a quarterly, prorated basis for each enrollee deemed eligible for case management services. The maximum number of enrollees who can be deemed eligible for enhanced payment is 2,000.

49 In 2002, for TANF/SCHIP enrollees, Oklahoma's monthly capitation rate was $659.72.

50 These mental health benefits include intensive outpatient services, psychosocial rehabilitation services, home-based services, rehabilitative case management, and therapeutic foster care.

51 Bethell CD, Read D, Stein RE, Blumberg SJ, Wells N, and Newacheck PW. "Identifying Children with Special Health Care Needs: Development and Evaluation of a Short Screening Instrument." *Ambulatory Pediatrics*, Jan-Feb 2002; 2(1).

52 The state reports that it has identified about five percent of the SCHIP population as having a complex condition because it requires enrollees to answer "yes" to all of the CSHCN screener questions, rather than just one.

Table 5: SCHIP Contract Requirements for Program Coordination, Treatment Plans, and Case Management, 2002

Care Oversight and Coordination Requirements	States
States with Requirements for Coordination with Public Program Providers Serving Special Needs Children	16 (41%)
Early intervention services	11 (69%)
Special education programs	11 (69%)
Children's mental health services	8 (50%)
Substance abuse programs	2 (13%)
Child welfare programs	8 (50%)
Title V programs	5 (31%)
States with Requirements for Treatment Plans or Plans of Care	17 (44%)
States with Requirements for Comprehensive Case Management	15 (38%)

We also found that 17 states using MCOs require them to develop treatment plans for children with special health care needs. States operating Medicaid SCHIP programs are more than three times as likely as states with separate programs to require treatment plans (75 percent vs. 22 percent). Eight of the 17 states link their treatment plan requirements to their general definition of the population of children with special needs. In these instances, treatment plans are usually intended for children with serious or disabling physical, mental, or developmental conditions. The other nine states limit eligibility for treatment plans to narrower populations, such as those with chronic or complex medical or physical needs, the developmentally disabled, or children with serious emotional disturbances. In addition, nine states have continuity-of-care provisions requiring MCOs to allow new enrollees to continue receiving ongoing treatment with an established provider. These contract provisions also are more common in states with Medicaid programs (31 percent vs. 17 percent). In most cases children may remain in the care of an out-of-network provider until they are appropriately transferred, but in others they may remain as long as it is in their best interests.

While nearly all of the 40 states include some reference to case management or care coordination in their SCHIP contracts, 15 states require MCOs to provide comprehensive case management intended to assist children in accessing and coordinating not only medical services, but also community-based services, social services, or appropriate educational supports. States with Medicaid programs are much more likely than states with separate programs to require comprehensive case management (63 percent vs. 22 percent). Of the 15 states, seven require comprehensive case management for the group of children described in their general definitions of children with special needs, which, again, usually incorporate children with serious or disabling physical, mental, or developmental conditions. The other eight states provide a definition specific to case management eligibility and tend to encompass only children with severe or complex medical or physical needs.

Two states have instituted comprehensive case management and treatment plan requirements. In both, the development of a treatment plan is considered part of case management. Interestingly, one of these states gives the case management and treatment plan responsibility to the enrollment broker.

- MCOs in New Jersey's separate program must provide comprehensive case management services and develop treatment plans for certain enrollees with complex special needs.[53] The treatment plan identifies short- and long-term goals, needed medical services and relevant social and support services, specialized communication and transportation needs, appropriate outcomes, barriers to effective outcomes, and timelines for care. Quality assurance officials from the SCHIP agency review MCOs' treatment plans on a quarterly basis to determine if services are actually provided.

[53] New Jersey's contract lists the following circumstances as possible indicators of a complex special need: poor health or functional status, existence of a care plan, existence of a case manager, a chronic condition, a recent hospitalization, recent critical social events, existence of multiple medical or social service systems or providers, use of prescription drugs — particularly multiple drugs, and use of an interpreter or any special service.

- Nebraska's Medicaid SCHIP program includes a special case management unit operated by the state's enrollment broker. The unit conducts needs assessments that include an evaluation of the child's medical condition and treatment history, including use of all specialty services and any relationships the child had with other community and public services as well as an assessment of medical and social risk factors. For children determined to require case management, a treatment plan is prepared as well as instructions on obtaining health and social services from other state and community-based agencies. Referrals may come from primary care providers, MCOs, or the Medicaid agency itself.

Provider Network Capacity and Access Requirements

Just over half of the 39 states enrolling SCHIP-eligible children with special health care needs into MCOs (20) had contract provisions in 2002 requiring that they have a sufficient number of experienced providers in their network to serve this population, as shown in Table 6. Such requirements are considerably more common among states with Medicaid programs than those with separate programs (63 percent vs. 44 percent). Overall, the 20 states typically stipulate that MCO networks have "pediatric" providers, although some refer to providers "with experience" serving children or special-needs populations in general. The type of required providers varies, however. Six of the states refer to all providers generally, but the majority of states specify provider types, most commonly pediatric subspecialists. One state requires contracting with three types of providers, while the others require contracting with one or two, but most often one.

Table 6: SCHIP Contract Requirements for Provider Capacity and Access, 2002

Provider Requirements	States
States with Pediatric Provider Capacity Requirements	20 (51%)
All providers	6 (30%)
Primary care providers	4 (20%)
Physician subspecialists	10 (50%)
Ancillary therapists	1 (5%)
Mental health providers	4 (20%)
Home health providers	1 (5%)
Hospitals	3 (15%)
States with Children's Public Program Contracting Requirements	13 (33%)
Early intervention program providers	1 (8%)
Title V program providers	7 (54%)
Community mental health centers	3 (23%)
Local health departments	6 (46%)
Other program providers	5 (38%)
States with Specialized Service Access Standards	28 (72%)
Appointment availability	24 (86%)
Travel time or distance standards	10 (36%)
Use of out-of-network providers	10 (36%)
No penalties on providers making specialty referrals	3 (11%)
Use of specialist as PCP	15 (54%)
Either use of specialist as PCP or direct access to a specialist	3 (11%)
Direct access provisions	15 (54%)
Direct access to specialists services	7 (25%)
Direct access to mental health services	9 (32%)
Direct access to dental services	2 (7%)
Direct access to vision services	3 (11%)

Requirements for MCOs to contract with public program providers serving children with special needs were less common, found in 13 states. Medicaid states are more than twice as likely as separate program states to have such requirements (50 percent vs. 22 percent). Although a few states specify two programs, the majority requires contracting only with a single program. Usually the requirement is that MCOs contract with local health departments or Title V program providers. In addition, ten states have contract language encouraging MCOs to contract with public program providers, most frequently providers of mental health services. Two of these states provide incentives — in one state MCOs that contract with community mental health centers are given preference in the plan selection process,[54] and in another state MCOs in each county that contract with the largest number of traditional and safety net providers may charge a lower monthly premium.[55]

Access standards relevant to children with special needs were far more likely to be included in states' managed care contracts than provider network or public program contracting requirements, as shown in Table 6. As many as 28 states enrolling SCHIP-eligible children in MCOs have at least one access standard pertaining to appointments or travel for specialty care. Such requirements are more likely to be found in Medicaid programs than in separate programs (81 percent vs. 65 percent). The most common access requirement, found in 24 states, is appointment availability standards, typically two days for urgent care and 30 days for non-urgent care. All states with appointment standards require access to specialty care generally, but ten also have appointment standards for particular specialty services, usually mental health and substance abuse services. Access requirements for distance or travel times to specialty services were found in ten states.

Other types of access requirements were used as well, most frequently by states with Medicaid programs. Ten states direct MCOs to allow children with special needs, or more commonly, all enrollees, to go out-of-network when an appropriate network provider is not available. Eighteen states have contract language concerning specialists serving as primary care providers, usually for enrollees with chronic conditions but sometimes for any enrollee, when specialists are the main source of care and are capable of assuming preventive and primary care responsibilities. Eight of these states require MCOs to allow specialists to serve as primary care providers, seven simply permit them to adopt such policies, and three give MCOs the option of either allowing specialists to serve as primary care providers or allowing direct access to specialists, essentially standing referrals. In addition, 15 states require MCOs to allow direct access to needed specialty services without the enrollee's having to obtain either a primary care provider referral or MCO authorization. Direct access provisions are more common for mental health services (nine states) than for medical specialty services (seven states), but this usually only establishes the members' right to self-refer for the initial visit. In two states, however, enrollees are guaranteed access to a course of visits — ranging from one to four — without prior plan approval.[56]

- Maryland's Medicaid SCHIP program has numerous contract provisions governing access to specialty services. MCOs are required to have a complete network of pediatric specialty care providers (including ancillary therapists and home health providers as well as subspecialists), to allow specialists to serve as primary care providers, and to pay for out-of-network care for new enrollees until an assessment is completed. Maryland's contract also establishes appointment standards for dental services, medical specialty care, and mental health services. In addition, MCOs are required to reschedule a missed follow-up appointment within 30 days and to contact the local health department for help in bringing enrollees into care if the second appointment is not kept.

[54] This state is Missouri.
[55] This state is California.
[56] These states are Connecticut and Missouri.

- Missouri's Medicaid SCHIP contract includes a variety of provider and access requirements governing mental health services. MCOs are directed to permit self-referral for mental health services for four visits in addition to the initial visit. They also must assure access to services within three days if an enrollee's primary care provider requests them. The state gives MCOs preference in the plan selection process for including community mental health centers in plan networks and requires all MCOs to include mental health providers with experience in treating children and adolescents in their networks.
- New Jersey's separate program, which uses the same contract it uses for its Medicaid program, requires MCOs to contract with a variety of providers with expertise in caring for children with special health care needs. These include pediatric subspecialists and primary care providers, dental providers with expertise in care of enrollees with developmental disabilities, and Title V and other specialty treatment centers.[57] Coordination with early intervention and special education programs, children's mental health programs, and developmental disability service organizations also is required. Enrollees with complex, specialized service needs also must be able to have a specialist as a primary care provider, have standing referrals to a specialist, and see out-of-network providers if an in-plan provider with appropriate training or experience is not available.
- MCO networks in Texas' separate program must include "significant traditional providers"[58] and, in rural areas, hospitals, physicians, home and community support service agencies, and any other health care providers who are the only providers in the service area. Referral relationships with Title V, community mental health centers, early intervention providers, and the local school districts also are required. The state has distance standards that are required for all managed care plans by the state's Department of Insurance for specialists, specialty hospitals, and psychiatric hospitals, but also requires MCOs to refer identified early intervention program eligibles to early intervention service providers within two days of identification. MCOs also must allow children with special health care needs to go out of network if an appropriate provider is not available, to have a specialist as their primary care provider, and to ensure that they have access to treatment by a multidisciplinary team when medically necessary for effective treatment.
- In Utah's separate program, which draws on the state's Medicaid contract for its safeguards, access to appropriate pediatric specialists, even if they are only available outside the plan's provider network, is required, and MCOs are prohibited from penalizing providers for making such referrals. MCO networks also must include multi-specialty clinics for children with particular conditions.[59] Direct access to one outpatient team evaluation by the Title V program and one follow-up visit also is required, and MCOs must reimburse the Title V program for these services. MCOs also are required to allow children with special health care needs to have as specialist as their primary care provider.

Although states with safeguard requirements in their contracts did not report any difficulties in establishing these requirements, particularly where plans had experience with Medicaid, monitoring the implementation of these safeguards was reportedly quite challenging. Many states, in fact, acknowledged that they are not doing much active monitoring of compliance with the requirements because it is costly, time-consuming, and staff intensive. States seem to be relying instead on quality reporting and on the complaints and grievances process to identify problems. Uncertainty about what is a meaningful safeguard or what standards should be was also mentioned by a couple of states. States also reported particular difficulties enforcing the provider network requirements because often there are simply insufficient numbers of providers available or willing to contract with the MCOs.

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[57] These agencies include pediatric ambulatory tertiary centers, regional cleft lip/palate centers, pediatric HIV treatment centers, PKU treatment centers, comprehensive regional sickle cell treatment centers, hemophilia treatment centers, and genetic counseling centers.

[58] Significant traditional providers are defined as all hospitals that received disproportionate share hospital (DSH) payments in state fiscal year 1999, and all other providers in a county that provided 80 percent of Medicaid billing in SFY 1998 or 1999.

[59] These conditions are spina bifida, sacral agenesis, cleft lip and palate, arthrogryposis, osteogenesis imperfecta, phocomelia, phenylketonuria, galactosaemia, cerebral palsy, and muscular dystrophy.

Conclusion

The majority of SCHIP programs using managed care organizations have adopted benefit policies and at least some managed care protections to address the particular service requirements of children with special health care needs. Specifically, we found at the beginning of 2002 that 21 of the 39 states are offering a full Medicaid benefit package and another four states are augmenting their basic SCHIP benefits for certain groups of children. Thirteen states include in their MCO contracts a medical necessity definition that encompasses services for preventive purposes and treatments for conditions or disabilities and does not include potentially restrictive requirements concerning cost and effectiveness. Importantly, three states have designed separate managed care plans specifically to serve children with special needs. In addition, 15 states include a definition of children with special needs in their MCO contracts, and 26 states stipulate a policy for identifying this population. Many states include one or more safeguards, including 17 states with treatment plan requirements, 15 states with comprehensive case management provisions, 20 states with pediatric provider network requirements, and 28 states with some type of specialty access requirement.

Several states stand out as having made extensive efforts on behalf of children with special health care needs: Florida and Michigan for augmenting their separate SCHIP program benefits and operating special capitated arrangements; Alabama, Arizona, California, Connecticut, Kansas, Nevada, and Washington for enriching their basic benefit package; and Delaware, Maryland, Massachusetts, New Jersey, Oklahoma, Texas, and Utah for implementing multiple safeguards to protect children who have been identified with special needs.

Overall, we found that Medicaid SCHIP programs offered more services and more comprehensive protections than separate programs. Although states with Medicaid programs are less likely to define or identify children with special health care needs, they are more likely to include language in their contracts that assures access to a variety of providers, the development of treatment plans, the provision of comprehensive case management, and coordination of services with other providers.

Since the SCHIP program began in 1997, there have been some notable changes in the number of states increasing income eligibility levels, specific benefits, and specialty access standards but little change in the number of states offering Medicaid-equivalent or wraparound benefits, specially designed managed care arrangements, and provider contracting standards. Specifically, ten states increased their income eligibility levels – five states with separate programs increased their eligibility levels to above 200 percent, in the case of one state to 350 percent,[60] and five states that originally relied on Medicaid have since added separate programs to cover children at higher income levels.[61] There also are seven states that began offering not only more generous mental health and substance abuse benefits, but also dental services, eyeglasses, and medical transportation as well. One of these states began offering Medicaid-equivalent benefits.[62] Finally, the number of states with access standards for specialty services almost doubled during this five-year period.

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60 These states are California, Maryland, New Jersey, New York, and Virginia.

61 These states are Indiana, Iowa, Maryland, Mississippi, and Texas. These states, with one exception had initially used SCHIP either to accelerate the phase in of Medicaid coverage for adolescents up to 100 percent of poverty or to increase the income eligibility for some or all children up to the 133 percent or 150 percent level in effect for younger children. At the beginning of 2002, these states had developed separate programs to cover children in families with incomes at or above 200 percent of poverty.

62 This state is Arizona. Massachusetts also began offering Medicaid-equivalent benefits for its separate program, but because we have categorized this state as a Medicaid program state, it is not counted in this total.

In the next five years, many SCHIP programs will likely face considerable fiscal challenges in sustaining and increasing their commitment to children with special health care needs. They will want to carefully consider different approaches to improving these children's care. States may need to examine, for example, whether the identification of a broader population of children with special health care needs will result in earlier identification of health problems and greater compliance with recommended standards of care, and whether specialty managed care plans and MCOs that contract with a broad array of pediatric providers achieve savings from volume performance and lower health care utilization. They also might need to evaluate whether offering Medicaid-equivalent benefits is actually much more expensive than offering a commercial benefit package. Looking more broadly, some states may want to consider whether MCO models or PCCM models are better able to meet the needs of children with chronic conditions. Finally, monitoring plan performance is expensive. It will continue to be important for states to explore alternative ways to structure financial and non-financial incentives to promote the delivery of comprehensive, high quality care to children with special needs.

Appendix Table I: Income Eligibility Levels in SCHIP and Medicaid Programs Using Managed Care Organizations,[1] 2002

States	SCHIP Eligibility Levels		Medicaid Eligibility Levels		
	Medicaid Programs	Separate SCHIP Programs	Infants	Children Ages One to Six	Older Children[2]
Alabama		200%	133%	133%	100%
Arizona		200%	140%	133%	100%
California		250%	200%	133%	100%
Colorado		185%	133%	133%	100%
Connecticut	185% (14-19)	300%	185%	185%	185% (6-14)
District of Columbia	200%		185%	133%	100%
Delaware		200% (1-19)	200%	133%	100%
Florida	200% (0-1)	200%[3]	185%	133%	100%
Hawaii	200%		185%	133%	100%
Illinois	200% (0-1) 133% (6-19)	185% (1-19)	133%	133%	100%
Indiana	150% (1-19)	200%	150%	133%	100%
Iowa	200% (0-1) 133% (6-19)	200%	185%	133%	100%
Kansas		200%	150%	133%	100%
Kentucky	150% (1-19)	200%	185%	133%	100%
Maryland	200%	300%	185%	185%	185% (6-15)[4] 100% (15-19)
Massachusetts	200% (0-1) 150% (1-19)	200%	185%	133%	133%
Michigan	150% (17-19)	200%	185%	150%	150% (6-17)
Minnesota	280% (0-2)		275%	275%	275%
Mississippi		200%	185%	133%	100%
Missouri	300%		185%	133%	100%
Montana		150%	133%	133%	100%
Nebraska	185%		150%	133%	100%
Nevada		200%	133%	133%	100%
New Hampshire	300% (0-1)	300%	185%	185%	185%
New Jersey	133% (6-19)	200%[5] 350%[5]	185%	133%	100%
New Mexico	235%		185%	185%	185%
New York		250%	200%	133%	133%
North Dakota		140%	133%	133%	100%
Ohio	200%		133%	133%	100%
Oklahoma	185%		150%	133%	100%
Oregon		170%	133%	133%	100%
Pennsylvania		200%	185%	133%	100%
Rhode Island	250% (8-19)		250%	250%	250% (0-8) 100% (8-19)
South Carolina	150% (1-19)		185%	133%	100%
Texas			185%	133%	100%
Utah		200%	133%	133%	100%
Virginia		200%	133%	133%	100%
Washington		200%	200%	200%	200%
Wisconsin	185% (6-19)[6]	250%	185%	185%	100%

Source: Information obtained by Maternal and Child Health Policy Research Center during telephone interviews with state SCHIP agency staff during the winter and spring of 2002 and through an analysis of states' SCHIP contracts in effect as of January 2002.

Appendix Table I Footnotes

[1] The states not using any capitated arrangements are Alaska, Arkansas, Georgia, Idaho, Louisiana, Maine, North Carolina, South Dakota, Vermont, West Virginia, and Wyoming.

[2] States were able to make children up to age 19 in families who were not eligible for Medicaid as of March 15, 1997 eligible for SCHIP on October 1, 1997, the effective date of the SCHIP legislation. However, the federal requirement that states phase in Medicaid eligibility for all children up to age 19 in families with incomes up to the federal poverty level remains in effect. As a result, the upper age limit for Medicaid eligibility at the poverty level continued to increase until October 1, 2002 when all children up to age 19 in families with incomes at the poverty level qualified for Medicaid. At the same time, the lower age limit for children in families with incomes up to the poverty level decreased for SCHIP.

[3] Florida's separate SCHIP program places children in families with incomes under 200 percent of poverty in two different plans, depending on the child's age. Children up to age five are enrolled in the MediKids program, which offers Medicaid benefits, and children between the ages of five and 19 are enrolled in the Healthy Kids program, which offers a narrower benefit package.

[4] Maryland's Medicaid SCHIP program covers and receives the enhanced matching rate for children up to age 15 in families with incomes from 185 percent to 200 percent of poverty and children ages 15 to 19 in families with incomes from 100 percent to 200 percent of poverty. Prior to the implementation of SCHIP, the state had a limited-benefit health insurance program, known as Kids Count, under a section 1115 demonstration waiver program for children up to age 15 with family incomes up to 185 percent of poverty. Kids Count ended with the advent of SCHIP, and participants became eligible for full Medicaid benefits. The state, but not the federal government, considers these children to be part of the SCHIP expansion population.

[5] New Jersey's separate SCHIP program consists of three plans with different cost requirements and benefits. Children in families with incomes up to 200 percent of poverty are placed in Plans B and C. Children in families between 200 and 300 percent of poverty are placed in KidsCare Plan D, which has a narrower benefits package.

[6] Wisconsin's Medicaid SCHIP program permits children enrolled in SCHIP to remain in the program as long as their family's income does not exceed 200 percent of poverty.

Appendix Table II: Benefit Packages in Separate SCHIP Programs, 2002

Services Authorized Under Title XXI	Alabama All Kids	Arizona KidsCare	California Healthy Families
Prescription drugs	Covered for generics unless generic substitution is not available	Covered	Covered
Over-the-counter drugs[1]	Not covered	Covered	
Inpatient mental health services[2]	Covered up to 30 days/year for inpatient services	Covered for inpatient and residential treatment center services	Not covered Covered for inpatient services up to 30 days/year; residential treatment services available through conversion of inpatient days
Outpatient mental health services[4]	Covered including community-based services up to 20 visits/year in combination with outpatient SA services	Covered for outpatient, partial hospitalization, and community-based services	Covered if condition is amenable to significant improvement through short-term therapy, up to 20 visits/year; additional days available through conversion of inpatient MH visits; partial hospitalization services available through conversion of inpatient days[3]
DME and other devices[5]	Covered	Covered	Covered except for therapeutic footwear
Disposable medical supplies	Covered	Covered	Covered for diabetic supplies
Home health services[6]	Covered for skilled nursing services and home health aide services up to 60 visits/year	Covered for skilled nursing services and home health aide services	Covered for skilled nursing services and home health aide services
Nursing care services	Covered for nurse practitioner services	Covered for nurse practitioner services and private duty nursing services	Covered for nurse practitioner services, and private duty nursing services
Dental services[7]	Covered up to $1,000/year	Covered	Covered
Inpatient substance abuse treatment services[2]	Covered up to 3 days/episode and up to 20 days/year	Covered for inpatient and residential treatment center services	Covered for detoxification
Outpatient substance abuse treatment services[4]	Covered including community-based services up to 20 visits/year in combination with outpatient MH services	Covered for outpatient, partial hospitalization, and community-based services	Covered up to 20 visits/year
Case management services[8]	Covered for individuals with catastrophic, long term, or chronic illness or injury	Covered for MH and SA conditions	Not covered
Physical, occupational, and speech therapy	Covered only if condition will improve	Covered for PT, OT, and ST for acute conditions if enrollee has potential for improvement. Covered for PT to restore, maintain, or improve muscle tone, joint mobility, or physical function but not covered as part of a maintenance regimen. Covered for OT to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost or reduced by illness or injury.	Covered for a 60-day period/condition, additional visits available if condition will improve significantly
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services[9]	Covered for audiology services; covered for chiropractic services up to 12 visits/year or $400/year; covered for optometry services; covered for SNFs up to 100 days/lifetimes; and covered for additional specialty services as medically necessary if child meets state-defined criteria	Covered for audiology services; covered for chiropractic services; covered for nutrition therapy; covered for optometry services; covered for podiatry services; covered for respiratory therapy; covered for SNFs up to 90 days/year; and covered for additional diagnostic and treatment services as medically necessary (EPSDT)	Covered for acupuncture up to 20 visits/year; covered for chiropractic services up to 20 visits/year; covered for optometry services; covered for short-term respiratory therapy at home; covered for SNFs up to 100 days/year; and covered for additional specialty services if child meets state-defined criteria
Medical transportation	Covered for emergencies	Covered	Covered
Enabling services	Covered for translation services	Covered for translation and outreach services	Covered for translation services

Covered = Benefits available with no limits specified

Appendix Table II: Benefit Packages in Separate SCHIP Programs, 2002 (continued)

Services Authorized Under Title XXI	**Colorado** Child Health Plan Plus	**Connecticut** HUSKY Part B	**Delaware** Delaware Healthy Children Program
Prescription drugs	Covered	Covered	Covered
Over-the-counter drugs[1]	Not covered	Not covered	Covered
Inpatient mental health services[2]	Covered without limits for certain neurobiologically based MH conditions[10] and up to 45 days for all other MH conditions	Covered for inpatient and residential treatment services without limits for most conditions; covered up to 60 days/year for other conditions	Covered up to 31 days/year in combination with inpatient SA services
Outpatient mental health services[4]	Covered without limits for certain neurobiologically based MH conditions[9] and covered up to 20 visits/year for all other MH conditions; partial hospitalization services available through conversion of inpatient days[12]	Covered without limits for most conditions; covered up to 30 visits/year for other conditions[10]	Covered including community-based services up to 30 visits/year in combination with outpatient SA services, with up to 31 additional visits available in combination with inpatient MH and SA services and additional outpatient SA services
DME and other devices[5]	Covered up to $2,000/year	Covered except for hearing aids	Covered
Disposable medical supplies	Covered for diabetic supplies	Covered	Covered
Home health services[6]	Covered for skilled nursing services and home health aide services	Covered for skilled nursing services and home health aide services	Covered for skilled nursing services and home health aide services
Nursing care services	Not covered	Covered for nurse practitioner services	Covered for private duty nursing services up to 28 hours/week
Dental services[7]	Covered up to $500/year	Covered	Not covered
Inpatient substance abuse treatment services[2]	Covered for detoxification up to 5 days/episode	Covered for inpatient services up to 60 days/year for drug abuse and 45 days/year for alcohol abuse	Covered up to 31 days/year in combination with inpatient MH services
Outpatient substance abuse treatment services[4]	Covered up to 20 visits/year	Covered up to 60 visits/year	Covered up to 30 visits/year in combination with outpatient MH services, with up to 31 additional visits available in combination with inpatient MH and SA services and additional outpatient MH services
Case management services[8]	Not covered	Not covered	Covered
Physical, occupational, and speech therapy	Covered up to 30 visits/year/condition	Covered for PT, OT, and ST for conditions where significant improvement is expected within 60 days	Covered
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services[9]	Covered for audiology services up to $800/year; covered for autism services; covered for treatment of intractable pain; covered for nutrition services; covered for optometry services; and covered for short-term SNFs	Covered for chiropractic services; covered for naturopathic services; covered for optometry services; covered for podiatry services; and covered for additional specialty services as medically necessary if child meets state-defined criteria	Covered for optometry services; covered for SNFs up to 30 days/year
Medical transportation	Covered	Covered for emergencies	Covered for emergencies
Enabling services	Not covered	Covered for translation services and outreach services	Not covered

Covered = Benefits available with no limits specified

Appendix Table II: Benefit Packages in Separate SCHIP Programs, 2002 (continued)

Services Authorized Under Title XXI	Florida Healthy Kids	Iowa Hawk-I[13]	Kansas HealthWave
Prescription drugs	Covered for generics unless brand names are medically necessary or generic substitution is not available	Covered	Covered
Over-the-counter drugs[1]	Not covered	Not covered	Covered
Inpatient mental health services[2]	Covered up to 30 days/year for inpatient; covered for residential treatment services in lieu of inpatient hospitalization	Covered for 30 days/year in combination with inpatient SA services	Covered for inpatient and residential treatment services only for biologically based mental conditions[14]
Outpatient mental health services[4]	Covered up to 40 visits/year for outpatient services	Covered for 30 visits/year in combination with outpatient SA services but excluding coverage for developmental and learning disorders, communication disorders, impulse control disorders, and sensitivity, shyness, and social withdrawal disorder	Covered for outpatient and partial hospitalization services only for biologically based mental conditions[13]
DME and other devices[5]	Covered	Covered except for therapeutic footwear	Covered
Disposable medical supplies	Covered	Covered	Covered
Home health services[6]	Covered for skilled nursing services	Covered for skilled nursing services and home health aide services when needed for treatment of illness or injury and when homebound	Covered for skilled nursing services and home health aide services
Nursing care services	Covered for inpatient private duty nursing services	Covered for nurse practitioner services and private duty nursing services	Covered for nurse practitioner and private duty nursing services
Dental services[7]	Covered[15]	Covered	Covered
Inpatient substance abuse treatment services[2]	Covered for detoxification up to 7 days/year; covered for residential treatment services up to 30 days/year	Covered for 30 days/year in combination with inpatient MH services	Covered up to 60 days/year for inpatient
Outpatient substance abuse treatment services[4]	Covered up to 40 visits/year for outpatient services	Covered for 30 visits/year in combination with outpatient MH services	Covered up to 25 visits/year; partial hospitalization services available through conversion of inpatient days
Case management services[8]	Not covered	Covered for catastrophic conditions	Covered
Physical, occupational, and speech therapy	Covered up to 24 visits within a 60-day period/episode or injury and only if condition will improve significantly	Covered for PT; covered for OT only to treat upper extremities; covered for ST when restorative for injury or illness	Covered for a minimum 180-day period when restorative for injury or acute episode
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services[9]	Covered for chiropractic services up to 12 visits/year; covered for optometry services; covered for podiatry services up to 24 visits/year; covered for SNFs up to 100 days/year; and covered for additional specialty services if child meets state-defined criteria	Covered for audiology services; covered for optometry services	Covered for audiology services; covered for chiropractic services; covered for nutrition services; covered for optometry services; covered for podiatry services up to 2 visits/year; and *covered for additional diagnostic and treatment services as medically necessary (EPSDT)*
Medical transportation	Covered for emergencies	Covered	Covered
Enabling services	Not covered	Not covered	Covered

Covered = Benefits available with no limits specified

Appendix Table II: Benefit Packages in Separate SCHIP Programs, 2002 (continued)

Services Authorized Under Title XXI	Michigan MIChild	Mississippi Mississippi Title XXI	Montana Montana's Children's Health Insurance Plan
Prescription drugs	Covered for generics unless brand names indicated by physician	Covered	Covered
Over-the-counter drugs[1]	Not covered	Not covered	Not covered
Inpatient mental health services[2]	Covered for inpatient and residential treatment center services	Covered up to 30 days/year for inpatient services in combination with residential treatment services	Covered without limits for certain conditions[17] and covered including services in a residential treatment center for other conditions up to 21 days/year, with additional days if child meets SED criteria
Outpatient mental health services[4]	Covered for outpatient, partial hospitalization, and community-based services	Covered up to 52 visits/year; covered for partial hospitalization services up to 60 days/year	Covered without limits for certain conditions[16] and up to 20 visits/year for other conditions; partial hospitalization services available through conversion of inpatient days;[18] covered for community-based services if child meets SED criteria
DME and other devices[5]	Covered	Covered	Covered for eyeglasses
Disposable medical supplies	Covered	Covered for diabetic supplies	Not covered
Home health services[6]	Covered for skilled nursing services and home health aide services up to 120 visits/year	Covered for skilled nursing services up to $10,000/year in combination with private duty nursing services	Not covered
Nursing care services	Covered for private duty nursing services	Covered for private duty nursing services up to $10,000/year in combination with skilled nursing services; covered for nurse practitioner services	Not covered
Dental services[7]	Covered up to $600/year	Covered for preventive and diagnostic services only	Covered up to $350/year
Inpatient substance abuse treatment services[2]	Covered for inpatient and residential treatment center services	Covered for inpatient and residential treatment services up to $8,000/year with a maximum of $16,000/lifetime in combination with outpatient SA services	Covered up to $6,000/year for a maximum of $12,000[19] in combination with outpatient SA services; covered for detoxification services without limit
Outpatient substance abuse treatment services[4]	Covered for outpatient, partial hospitalization services, and community-based services	Covered up to $8,000/year with a maximum of $16,000/lifetime in combination with inpatient SA services	Covered up to $6,000/year for a maximum of $12,000 in combination with inpatient SA services
Case management services[8]	Covered only for MH conditions through CMHCs	Not covered	Not covered
Physical, occupational, and speech therapy	Covered to restore or improve a functional loss caused by injury, illness, disease, or congenital anomaly	Covered for PT and OT. Covered for ST for conditions resulting from accidental injury or illness and only if condition will improve and excluding coverage for maintenance speech, delayed language development, and articulation disorders.	Not covered
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services[9]	Covered for acupuncture up to 20 visits/year for certain conditions; covered for audiology services; covered for chiropractic services; covered for optometry services; covered for SNFs up to 120 days/admission; and covered for additional specialty services as medically necessary if child meets state-defined criteria	Covered for audiology services; covered for chiropractic services up to $1,500/year; covered for optometry services; covered for diabetes self management and education services such as medical nutrition therapy up to $250/year; covered for SNFs up to 60 days/year	Covered for audiology services; covered for optometry services
Medical transportation	Covered for emergencies	Covered for emergencies	Not covered
Enabling services	Not covered	Not covered	Not covered

Covered = Benefits available with no limits specified

Appendix Table II: Benefit Packages in Separate SCHIP Programs, 2002 (continued)

Services Authorized Under Title XXI	Nevada Nevada Check Up	New Hampshire Healthy Kids Silver	New Jersey NJKidCare Plans B and C and D[20]
Prescription drugs	Covered	Covered	Covered
Over-the-counter drugs[1]	Covered	Not covered	Covered
Inpatient mental health services[2]	Covered	Covered for inpatient services up to 15 days/year	Plans B and C: Covered for inpatient and residential treatment services Plan D: Covered up to 35 days/year for inpatient services
Outpatient mental health services[4]	Covered including community-based services	Covered primarily for acute episodes of certain neurologically based mental conditions[21] without limits and covered for all other MH conditions up to 20 visits/year in combination with outpatient SA services; coverage for partial hospitalization services available through conversion of inpatient MH days[22]	Plans B and C: Covered including community-based services for outpatient and partial hospitalization services Plan D: Covered up to 20 visits/year with additional visits available through conversion of inpatient MH days;[23] coverage for partial hospitalization services available through conversion of inpatient days.[22]
DME and other devices[5]	Covered	Covered except for therapeutic footwear	Plans B and C: covered Plan D: Not covered
Disposable medical supplies	Covered	Covered	Plans B and C: Covered Plan D: Covered for diabetic supplies
Home health services[6]	Covered for skilled nursing, home health aide, and personal care services	Covered for skilled nursing services and home health aide services up to 20 visits/year	Covered for skilled nursing services and home health aide services
Nursing care services	Covered for nurse practitioner services and private duty nursing services	Not covered	Plans B and C: Covered for nurse practitioner services, and private duty nursing services Plan D: Covered for nurse practitioner services
Dental services[7]	Covered	Covered	Plans B and C: Covered Plan D: Covered for preventive services for children under age 12
Inpatient substance abuse treatment services[2]	Covered	Covered for detoxification	Plans B and C: Covered Plan D: Covered for detoxification services
Outpatient substance abuse treatment services[4]	Covered	Covered primarily for acute episodes up to 20 visits/year in combination with outpatient MH services	Plans B and C: Covered Plan D: Covered for detoxification services
Case management services[8]	Covered	Not covered	Plans B and C: Covered for the chronically mentally ill Plan D: Not covered
Physical, occupational, and speech therapy	Covered	Covered for acute conditions and excluding developmental disabilities, up to 24 visits/year for ST and up to 24 visits/year for any combination of PT and OT only if condition will improve significantly	Plans B and C: Covered up to 60 visits/year for each type of therapy Plan D: PT and OT covered up to 60 days/incident of illness or injury for non-chronic conditions and acute illness and injuries; ST covered up to 60 days/incident of illness or injury only for conditions resulting from disease, injury, or congenital defects
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services[9]	Covered for audiology, chiropractic, early intervention, optometry, podiatry, and school-based rehabilitation services; covered for SNFs; and covered for additional diagnostic and treatment services as medically necessary (EPSDT)	Covered for chiropractic services; covered for diabetic monitoring and nutrition services; covered for optometry services; covered for rehabilitation facilities; and covered for SNFs.	Plans B and C: Covered for audiology, chiropractic, optometry, podiatry, and school-based rehabilitation services; covered for SNFs Plan D: Covered for optometry services; covered for podiatry services; covered for SNFs
Medical transportation	Covered	Covered for emergencies	Plans B and C: Covered Plan D: Covered for emergencies
Enabling services	Not covered	Not covered	Not covered

Covered = Benefits available with no limits specified

Appendix Table II: Benefit Packages in Separate SCHIP Programs, 2002 (continued)

Services Authorized Under Title XXI	New York Child Health Plus	North Dakota Healthy Steps	Oregon Oregon Health Plan
Prescription drugs	Covered	Covered	Covered, but excluding certain conditions[24]
Over-the-counter drugs[1]	Covered	Not covered	Covered, but excluding certain conditions[23]
Inpatient mental health services[2]	Covered up to 30 days/year in combination with inpatient SA services	Covered up to 60 days/year in combination with inpatient SA services; covered for residential treatment services up to 120 days/year	Covered, including services in a residential program, but excluding certain conditions[23]
Outpatient mental health services[4]	Covered up to 60 visits/year in combination with outpatient SA services	Covered up to 30 visits/year; covered for partial hospitalization services up to 120 days/year with additional days available through conversion of inpatient days[25]	Covered, but excluding certain conditions[23]
DME and other devices[5]	Covered	Covered up to $6,000/year in combination with medical supplies	Covered, but excluding certain conditions[23]
Disposable medical supplies	Covered for diabetic supplies	Covered up to $6,000/year in combination with DME	Covered, but excluding certain conditions[23]
Home health services[6]	Covered for skilled nursing services and home health aide services in lieu of SNF or hospital care and for at least 40 visits/year	Covered for skilled nursing services and home health aides in lieu of SNF or hospital care	Covered, but excluding certain conditions[23] for skilled nursing services and home health aide services
Nursing care services	Not covered	Covered for private duty nursing services	Covered, but excluding certain conditions[23] for nurse practitioner services and private duty nursing services
Dental services[7]	Covered	Covered	Covered, but excluding certain conditions[23]
Inpatient substance abuse treatment services[2]	Covered up to 30 days/year in combination with inpatient MH services	Covered up to 60 days/year in combination with inpatient MH; covered for detoxification services up to 5 days/admission[26]	Covered, including services in a residential program but excluding certain conditions[23]
Outpatient substance abuse treatment services[4]	Covered up to 60 visits/year in combination with outpatient MH services	Covered up to 20 visits/year	Covered, but excluding certain conditions[23]
Case management services[8]	Not covered	Not covered	Covered, but excluding certain conditions[23]
Physical, occupational, and speech therapy	Covered for conditions amenable to significant clinical improvement within 60 days	Covered for PT to restore maximum function following disease, injury, or loss of body part; covered for OT up to 90 consecutive days/condition for physical disabilities if therapies are designed to promote restoration of ability to satisfactorily accomplish ordinary tasks of daily living; covered for ST for correction of speech impairments resulting from disease, surgery, injury, congenital anomaly, or previous therapeutic process	Covered, but excluding certain conditions[23]
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services[9]	Covered for diabetic monitoring, nutrition services and management through home visitation; covered for optometry services	Covered for chiropractic services except for maintenance care; covered for nutrition services for certain conditions;[27] covered for optometry services up to 16 visits/lifetime; and covered for SNFs	Covered for audiology services but excluding certain conditions;[23] covered for optometry services but excluding certain services;[23] covered for school-based rehabilitation services[23]
Medical transportation	Covered	Covered for emergencies	Covered
Enabling services	Not covered	Not covered	Covered for translation services

Covered = Benefits available with no limits specified

Appendix Table II: Benefit Packages in Separate SCHIP Programs, 2002 (continued)

Services Authorized Under Title XXI	**Pennsylvania** Pennsylvania Child Health Insurance Plan	**Texas** Texas' Children's Health Insurance Program	**Utah** Utah CHIP
Prescription drugs	Covered	Covered	Covered
Over-the-counter drugs[1]	Not covered	Not covered	Not covered
Inpatient mental health services[2]	Covered for inpatient services up to 90 days/year in combination with acute inpatient care; additional days available through conversion of outpatient visits[28]	Covered up to 45 days/year including residential treatment services	Covered up to 30 days/year for inpatient services in combination with residential treatment services, but excluding conditions such as conduct disorders, oppositional disorders, and learning disabilities, in combination with inpatient SA services
Outpatient mental health services[4]	Covered up to 50 visits/year	Covered up to 60 visits/year, including community-based services; covered up to 60 days/year for partial hospitalization services	Covered, but excluding conditions such as conduct disorders, oppositional disorders, and learning disabilities up to 30 visits/year in combination with outpatient SA services
DME and other devices[5]	Covered	Covered up to $20,000/year	Covered, except for eyeglasses and therapeutic footwear
Disposable medical supplies	Covered	Covered	Covered
Home health services[6]	Covered for skilled nursing services up to 60 visits/year	Covered for home health aide services and skilled nursing services	Covered for skilled nursing services
Nursing care services	Covered for nurse practitioner services and private duty nursing services	Covered for private duty nursing services	Covered for nurse practitioner services
Dental services[7]	Covered	Covered up to $300/year for therapeutic dental services but covered without limit for conditions related to existing health care condition; covered for preventive dental benefits up to $172/year for children up to age 13 and up to $181 for children ages 13-18	Covered for cleanings only
Inpatient substance abuse treatment services[2]	Covered for detoxification up to 7 days/year with a maximum of 4 admissions/lifetime; covered for residential treatment services up to 30 days/year with a maximum of 90 days/lifetime	Covered for detoxification/crisis stabilization up to 14 days/year; residential treatment services covered up to 60 days/year;[29] maximum of 3 episodes/lifetime	Covered up to 30 days/year in combination with inpatient MH services
Outpatient substance abuse treatment services[4]	Covered up to 30 days/year with a maximum of 120 days/lifetime	Covered for intensive outpatient rehabilitation up to 12 weeks/year; covered for outpatient visits up to 6 months/year; maximum of 3 episodes/lifetime	Covered up to 30 visits/year in combination with outpatient MH services
Case management services[8]	Covered for MH conditions	Covered for children with complex chronic conditions	Not covered
Physical, occupational, and speech therapy	Covered for a 60-day period/condition/lifetime if condition will improve significantly	Covered	Covered, but excluding therapies for children with developmental delay for OT for fine motor function and PT up to 16 visits/year in combination with chiropractic services and for ST without limits for restoring speech loss or to correct impairment due to congenital defect or an injury or sickness
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services[9]	Covered for audiology services; covered for optometry services; covered for respiratory therapy; covered for SNFs in lieu of hospitalization	Covered for chiropractic services; covered for respiratory therapy; and covered for SNFs up to 60 days/year	Covered for chiropractic services up to 16 visits/year in combination with OT and PT; covered for optometry services; covered for podiatry services
Medical transportation	Covered	Covered	Covered for emergencies
Enabling services	Not covered	Not covered	Not covered

Covered = Benefits available with no limits specified

Appendix Table II: Benefit Packages in Separate SCHIP Programs, 2002 (continued)

Services Authorized Under Title XXI	Virginia Family Access to Medical Insurance Security Plan	Washington Washington's Children's Health Insurance Plan
Prescription drugs	Covered	Covered
Over-the-counter drugs[1]	Not covered	Covered
Inpatient mental health services[2]	Covered for services in a general hospital in combination with partial hospitalization services up to 30 days/year	Covered
	Covered including community-based services up to 50 visits/year and covered for partial hospitalization services in combination with inpatient MH services up to 30 days/year	Covered including community based services
Outpatient mental health services[4]	Covered	Covered
DME and other devices[5]	Covered	Covered
Disposable medical supplies	Covered for skilled nursing services and home health aide services up to 90 visits/year	Covered for skilled nursing services, home health aide services, and personal care services
Home health services[6]	Covered for private duty nursing services	Covered for nurse practitioner services and private duty nursing services
Nursing care services	Covered up to $1,200year	Covered
Dental services[7]	Covered up to 90 days/lifetime	Covered
Inpatient substance abuse treatment services[2]	Covered up to 50 visits/year	Covered
Outpatient substance abuse treatment services[4]	Not covered	Covered for maternity case management
Case management services[8] Physical, occupational, and speech therapy	Covered to treat or promote recovery from illness or injury	Covered
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services[9]	Covered for audiology services; covered for chiropractic services up to $500/year; covered for early intervention services up to $5,000/year; covered for optometry services; covered for rehabilitation facilities; covered for school-based rehabilitation services; covered for SNFs up to 180 days/episode	Covered for audiology services; covered for health education services for certain conditions; covered for neurodevelopmental center services; covered for optometry services; covered for respiratory therapy; covered for podiatry services; covered for school-based rehabilitation services; covered for SNFs; and covered for additional diagnostic and treatment services as medically necessary (EPSDT)
Medical transportation	Covered for emergencies	Covered
Enabling services	Not covered	Covered for translation services

Covered = Benefits available with no limits specified

Source: Information obtained by Maternal and Child Health Policy Research Center during telephone interviews with state SCHIP agency staff during the winter and spring of 2002 and through an analysis of states' SCHIP contracts in effect as of January 2002.

CMHCs = Community mental health centers
DME = Durable medical equipment
EPSDT = Early and periodic screening, diagnosis, and treatment
MH = Mental health
OT = Occupational therapy
PT = Physical therapy
SA = Substance abuse
SED = Serious emotional disturbances
SNFs = Skilled nursing facilities
ST = Speech therapy or speech language and pathology services

Appendix Table II Footnotes

1 Over-the-counter drugs are assumed not to include any disposable medical supplies, such as needles and diabetic testing strips.

2 As part of inpatient psychiatric services, SCHIP programs may choose to cover treatment services in a residential program or the full cost of a stay in a residential facility (including room and board). There has been confusion among states concerning payment for residential facilities and in 1998 HCFA issued new rules to clarify this issue with respect to Medicaid. (Health Care Financing Administration's Final Rule on Inpatient Psychiatric Services Benefit for Individuals Under Age 21. Federal Register. 63: 64195-64199, November 19, 1998.)

3 In California, one inpatient hospital day may be converted to three partial hospitalization services, four outpatient visits, or two residential treatment days.

4 Community-based services typically include day treatment services, intensive in-home services, and crisis stabilization as well as additional outpatient therapy visits and usually are furnished through community mental health centers.

5 DME and other devices, as defined in the Title XXI statute, include eyeglasses and hearing aids.

6 Home health services include, in addition to skilled nursing services, home health aides, personal care services, and respite care services. Skilled nursing services, according to the American Nurses Association, include services provided by registered nurses, licensed practical nurses, licensed vocational nurses, and advanced practice registered nurses.

7 Dental services are assumed to include preventive, diagnostic, and restorative services for oral health.

8 Case management services are assumed to include care coordination services for identified child populations only.

9 Optometry services are assumed to be vision examinations beyond the vision screening performed in a primary care physician's office and not to include eyeglasses.

10 In Colorado, neurologically based mental conditions are defined as schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Neurobiologically based mental illness is required to be treated as any other illness or condition under the state's parity law.

11 In Connecticut, conditions that are covered with limits are mental retardation, learning disorders, motor skills disorders, communication disorders, caffeine-related disorders, relational problems, and conditions that are not defined as mental disorders in the DSM-IV.

12 In Colorado, one inpatient hospital day may be converted to two partial hospitalization services.

13 In Iowa, the state allows participating MCOs to establish their own SCHIP benefit packages as long as they are actuarially equivalent to the state employees' benefit package. The benefits listed here are those provided by the MCO with the largest SCHIP enrollment.

14 In Kansas, biologically based mental conditions are defined as schizophrenia, schizo-affective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorders (bipolar disorder and major depression), cyclothymic and dysthymic disorders, obsessive compulsive disorder, panic disorder, pervasive developmental disorder (including autism), attention deficit hyperactive disorder, and borderline personality disorder.

15 In Florida's separate SCHIP program, dental benefits are offered on a statewide basis as of June 1, 2002.

16 In Kansas, one inpatient day may be converted to two partial hospitalization visits for substance abuse conditions.

17 In Montana, there are no limits on inpatient or outpatient mental health services for schizophrenia, schizo-affective disorder, bipolar disorder, panic disorder, major depression, obsessive-compulsive disorder, or autism.

18 In Montana, one inpatient hospital day may be converted to two partial hospitalization services.

19 In Montana, after the maximum has been met for the substance abuse benefit, the annual benefit decreases to $2,000.

20 In New Jersey, KidCare Plans B and C cover children in families with incomes up to 200 percent of poverty, and KidCare Plan D covers children in families with incomes between 200 percent to 350 percent of poverty.

21 In New Hampshire, conditions that are covered without limits are schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder, including autism.

22 In New Hampshire, one inpatient hospital day may be converted to two partial hospitalization services.

23 In New Jersey's KidCare Plan D, one inpatient hospital day may be converted to four outpatient visits or two partial hospitalization services.

24 In Oregon, actual covered services are those that are listed as prioritized services for conditions covered under the state's 1115 Medicaid demonstration waiver program

25 In North Dakota, one inpatient hospital day may be converted to two partial hospitalization services.

26 In North Dakota, use of the detoxification benefit reduces the covered inpatient substance abuse benefit.

27 In North Dakota, nutrition services are covered for diabetes, hyperlipidaemia (up to two visits/year), eating disorders, chronic renal failure, and phenylketonuria.

28 In Pennsylvania, two outpatient visits may be converted to one inpatient day.

29 In Texas, one residential treatment day may be converted to one partial hospitalization service, one intensive outpatient rehabilitation service, or one outpatient visit. A maximum of 30 days may be converted.

30 In Washington, health education and nutritional counseling services are covered for diabetes, high blood pressure, and anemia.

Appendix Table III: Enrollment Requirements in SCHIP Programs Using Managed Care Organizations, 2002

States	Mandatory Enrollment into MCOs[1]		Voluntary Enrollment into MCOs[2]	
	Statewide	Some or Most Counties	Statewide	Some or Most Counties
Alabama[3]	✓			
Arizona	✓			
California	✓			
Colorado[4]		✓		
Connecticut	✓			
Delaware	✓			
District of Columbia	✓			
Florida[5]	✓			
Hawaii	✓			
Illinois				✓
Indiana			✓	
Iowa	✓			
Kansas	✓			
Kentucky		✓		
Maryland	✓			
Massachusetts			✓	
Michigan	✓			
Minnesota	✓			
Mississippi[6]	✓			
Missouri		✓		
Montana[7]	✓			
Nebraska				✓
Nevada		✓		
New Hampshire	✓			
New Jersey	✓			
New Mexico	✓			
New York	✓			
North Dakota[8]	✓			
Ohio[9]		✓		
Oklahoma		✓		
Oregon	✓			
Pennsylvania	✓			
Rhode Island	✓			
South Carolina				✓
Texas	✓			
Utah[10]		✓		
Virginia		✓		
Washington[11]		✓		
Wisconsin		✓		
Total	**24**	**10**	**2**	**3**

Source: Information obtained by Maternal and Child Health Policy Research Center during telephone interviews with state SCHIP agency staff during the winter and spring of 2002 and through an analysis of states' SCHIP contracts in effect as of January 2002.

Appendix Table III Footnotes

[1] This category includes states that mandate SCHIP children to enroll into an MCO and also states operating Medicaid programs that allow children to choose between enrolling into an MCO or a primary care case management system (PCCM) but use the MCO as the default mandatory arrangement if the child fails to make a choice.

[2] This category includes states that permit SCHIP children to choose between an MCO and a fee-for-service arrangement and also states operating Medicaid programs that allow SHIP children to choose between enrolling into an MCO and a PCCM but use the PCCM as the default mandatory arrangement if the child fails to make a choice.

[3] In Alabama's separate SCHIP program, AllKids, children must enroll in BlueCross BlueShield, an indemnity plan, which receives a monthly premium for providing SCHIP services.

[4] In Colorado's separate SCHIP program, Child Health Plan Plus, children in 37 counties must enroll in an HMO. In the remaining 33 counties, the state operates its own SCHIP network, and eligible children must receive services from providers in this network. A third party administers this network and receives a monthly estimated capitation payment, but it does not assume full risk.

[5] In Florida's separate SCHIP program, Healthy Kids, children between the ages of five and 19 must enroll into an MCO. The separate SCHIP program for children under the age of five allows for enrollment into either capitated plans or a primary care case management system.

[6] In Mississippi's separate SCHIP program, children must enroll in BlueCross BlueShield, an indemnity plan, which receives a monthly premium for providing SCHIP services.

[7] In Montana's separate SCHIP program, Montana's Children's Health Insurance Plan, children must enroll in BlueCross BlueShield, an indemnity plan, which receives a monthly premium for providing SCHIP services.

[8] In North Dakota's separate SCHIP program, Healthy Steps, children must enroll in BlueCross BlueShield, an indemnity plan, which receives a monthly premium for providing SCHIP services.

[9] In Ohio's Medicaid program, children must enroll in a capitated plan in four of the state's 88 counties. In four other counties, SCHIP-eligible children are automatically enrolled into a capitated plan but have the option to disenroll and receive services on a fee-for-service basis. In seven counties, the option to enroll in a capitated plan is purely voluntary.

[10] In Utah's separate SCHIP program, children in four counties must enroll in a capitated plan. In the remaining counties, children must enroll in a preferred provider organization, which is paid an estimated monthly capitation payment, but it does not assume full risk.

[11] In Washington's separate SCHIP program, children in 26 counties must enroll in a capitated plan. In the remaining 12 counties, where there is only one capitated plan operating, enrollees may enroll in the plan or receive services on a fee-for-service basis.